SURGERY

USER MANUAL

Version 3.0
July 1993

(Revised August 2004)

Department of Veterans Affairs
V*IST***A** Health Systems Design & Development

Revision History

Each time this manual is updated, the Title Page lists the new revised date and this page describes the changes. Either update the existing manual with the Change Pages document, or replace it with the updated manual.

Note: The Change Pages document may include unedited pages needed for two-sided copying. Only edited pages display the patch number and revision date in the page footer.

Date	Revised Pages	Patch Number	Description
08/04	iv-vi, 187-189, 195, 195a-195b, 196, 207-208, 219a-b, 527-528	SR*3*132	Updated the Table of Contents and Index to reflect added options. Added the new *Non-OR Procedure Information* option and the *Tissue Examination Report* option (unrelated to this patch) to the Non-OR Procedures section.
08/04	31, 43, 46, 66, 71-72, 75-76, 311	SR*3*127	Updated screen captures to display new text for ICD-9 and CPT codes.
08/04	vi, 437, 439, 441-452, 454-455, 457, 459, 461, 463-464, 464a-b, 465-466, 466a-b, 467, 469-470, 470a-b, 471-475, 475a-b, 476-482, 482a-b, 515, 527-530	SR*3*125	Updated the Table of Contents and Index. Clarified the location of the national centers for NSQIP and CICSP. Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software and new options have been added. For an overview of the data entry changes, see the *Surgery NSQIP/CICSP Enhancements 2004 Release Notes.* Added the *Laboratory Test Result (Enter/Edit)* option and the *Outcome Information (Enter/Edit)* option to the *Cardiac Risk Assessment Information (Enter/Edit)* menu section. Changed the name of the *Cardiac Procedures Requiring CPB (Enter/Edit*) option to *Cardiac Procedures Operative Data (Enter/Edit)* option. Removed the *Update Operations as Unrelated/Related to Death* option from the *Surgery Risk Assessment Menu*.
08/04	6-10, 14, 103, 105-107, 109-112, 114-120, 122-124, 141-152, 218-219, 284-287, 324, 370-377	SR*3*129	Updated examples to include the new levels for the Attending Code (or Resident Supervision). Also updated examples to include the new fields for ensuring Correct Surgery. For specific options affected by each of these updates, please see the *Resident Supervision/Ensuring Correct Surgery Phase II Release Notes.*

Date	Revised Pages	Patch Number	Description
04/04	All	SR*3*100	All pages were updated to reflect the most recent Clinical Ancillary Local Documentation Standards and the changes resulting from the Surgery Electronic Signature for Operative Reports project, SR*3*100. For more information about the specific changes, see the patch description or the *Surgery Electronic Signature for Operative Reports Release Notes*.

Table Of Contents

Non-O.R. Procedures
[SRONOP]

The *Non-O.R. Procedures* option, located in the main *Surgery Menu* and locked with the SROPER key, is designed for documenting and reviewing Non-O.R. Procedures.

A Non-O.R. Procedure is any procedure not performed in an operating room, but which still involves surgical or anesthesia providers. Any procedures involving anesthesia providers will display on the Anesthesia AMIS Report.

The main options included in this menu are listed below. The first option, *Non-O.R.. Procedures (Enter Edit)*, contains options to enter or update cases. To the left of the option name is the shortcut synonym the user can enter to select the option.

Shortcut	Option Name
E	*Non-O.R.. Procedures (Enter/Edit)*
A	*Annual Report of Non-O.R.. Procedures*
R	*Report of Non-O.R.. Procedures*
	Tissue Examination Report

Non-O.R. Procedures (Enter/Edit)
[SRONOP-ENTER]

The *Non-O.R. Procedures (Enter/Edit)* option allows the user to enter, edit, or delete information related to a Non-O.R. Procedure. The editing feature branches to another submenu that allows the user to enter or edit anesthesia information for a procedure. To use one of the *Non-O.R. Procedures (Enter/Edit)* options, the user must first identify the patient on which he or she is working.

Accessing the Non-O.R. Procedures Menu

When the *Non-O.R. Procedures (Enter/Edit)* option is selected, the user will be prompted to enter a patient name. The Surgery software will then list all non-O.R. procedures on record for the patient.

```
 NEBRASKA,NICK   123-45-6789

1. APR 22, 2002     BRONCHOSCOPY

2. NEW PROCEDURE

Select Procedure: 1
```

The user can select from the procedure(s) listed or enter a new procedure. When selecting an existing procedure, the software will ask whether the user wants to 1) edit information for the case, or 2) delete the procedure, as follows.

```
 NEBRASKA,NICK   123-45-6789

 APR 22, 2002       BRONCHOSCOPY


Do you want to edit or delete this procedure ?

1. Edit
2. Delete

Select Number:  1// 1
```

If the user enters **2** to delete, the software will permanently remove the procedure from the records. On the other hand, if the user accepts the default answer, **1**, to edit the existing procedure, the software will display the *Non-O.R. Procedures (Enter/Edit)* menu option. The user will see the following options.

```
 NEBRASKA,NICK (123-45-6789)   Case #267260 - APR 22,2002


   E      Edit Non-O.R. Procedure
   AI     Anesthesia Information  (Enter/Edit)
   AM     Medications (Enter/Edit)
   AT     Anesthesia Technique (Enter/Edit)
   PR     Procedure Report (Non-O.R.)
   TR     Tissue Examination Report
   I      Non-OR Procedure Information

Select Non-O.R. Procedures (Enter/Edit) Option:
```

Three of these sub-options, the *Anesthesia Information (Enter/Edit)* option, the *Medications (Enter/Edit)* option, and the *Anesthesia Technique (Enter/Edit)* option, are the same as the sub-options of the same name on the *Anesthesia Menu* option.

Edit Non-O.R. Procedure
[SRONOP-EDIT]

The *Edit Non-O.R. Procedure* option on the *Non-O.R. Procedures* menu allows the user to enter or edit data on the selected procedure.

The DICTATED SUMMARY EXPECTED field is used to determine whether a dictated summary will be required for this Non-O.R. Procedure case. If **NO** is entered into the DICTATED SUMMARY EXPECTED field, no alerts will be generated and no report information will be displayed. If **YES** is entered into the DICTATED SUMMARY EXPECTED field, an alert will be sent to the appropriate provider informing him or her that the Procedure Summary is ready for signature.

The DICTATED SUMMARY EXPECTED field is used to determine whether a dictated summary will be required for a Non-O.R. Procedure case.

Example: Setting the DICTATED SUMMARY EXPECTED field to YES

```
NEBRASKA,NICK (123-45-6789)   Case #267260 - APR 22,2002


   E      Edit Non-O.R. Procedure
   AI     Anesthesia Information  (Enter/Edit)
   AM     Medications (Enter/Edit)
   AT     Anesthesia Technique (Enter/Edit)
   PR     Procedure Report (Non-O.R.)
   TR     Tissue Examination Report
   I      Non-OR Procedure Information

Select Non-O.R. Procedures (Enter/Edit) Option: E  Edit Non-O.R. Procedure
```

```
** NON-O.R. PROCEDURE **   CASE #267260  NEBRASKA,NICK PAGE 1 OF 3

1    DATE OF PROCEDURE:  APR 22, 2002
2    PRINCIPAL PROCEDURE: BRONCHOSCOPY
3    PRINCIPAL PROCEDURE CODE:
4    MEDICAL SPECIALTY:  GENERAL SURGERY
5    DICTATED SUMMARY EXPECTED:
6    IN/OUT-PATIENT STATUS:
7    TIME PROCEDURE BEGAN:
8    TIME PROCEDURE ENDED:
9    PROVIDER:           MIAMI,STEVE
10   NON-OR LOCATION:
11   ASSOCIATED CLINIC:
12   PRINCIPAL DIAGNOSIS:
13   PRIN DIAGNOSIS CODE:
14   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
15   BRIEF CLIN HISTORY: (WORD PROCESSING)

Enter Screen Server Function:  5
Dictated Summary Expected: YES  YES
```

```
** NON-O.R. PROCEDURE **   CASE #267260  NEBRASKA,NICK PAGE 1 OF 3

1    DATE OF PROCEDURE:  APRIL 22, 2002
2    PRINCIPAL PROCEDURE: BRONCHOSCOPY
3    PRINCIPAL PROCEDURE CODE:
4    MEDICAL SPECIALTY:  GENERAL SURGERY
5    DICTATED SUMMARY EXPECTED: YES
6    IN/OUT-PATIENT STATUS:
7    TIME PROCEDURE BEGAN:
8    TIME PROCEDURE ENDED:
9    PROVIDER:           MIAMI, STEVE
10   NON-OR LOCATION:
11   ASSOCIATED CLINIC:
12   PRINCIPAL DIAGNOSIS:
13   PRIN DIAGNOSIS CODE:
14   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
15   BRIEF CLIN HISTORY: (WORD PROCESSING)

Enter Screen Server Function: <Enter>
```

```
** NON-O.R. PROCEDURE **   CASE #267260  NEBRASKA,NICK PAGE 2 OF 3

1    OPERATIVE FINDINGS: (WORD PROCESSING)
2    ATTEND PROVIDER:
3    ATTENDING CODE:
4    PRINC ANESTHETIST:
5    ANESTHESIOLOGIST SUPVR:
6    ANES CARE START TIME:
7    ANES CARE END TIME:
8    ANESTHESIA TECHNIQUE: (MULTIPLE)
9    ANES SUPERVISE CODE:
10   DIAGNOSTIC/THERAPEUTIC (Y/N):
11   ASA CLASS:
12   OTHER PROCEDURES:   (MULTIPLE)
13   OTHER POSTOP DIAGS: (MULTIPLE)
14   PROCEDURE OCCURRENCE: (MULTIPLE)
15   SPECIMENS:          (WORD PROCESSING)

Enter Screen Server Function: <Enter>
```

```
** NON-O.R. PROCEDURE **   CASE #267260  NEBRASKA,NICK PAGE 3 OF 3

1    GENERAL COMMENTS:   (WORD PROCESSING)
2    CANCEL DATE:
3    CANCEL REASON:

Enter Screen Server Function:
```

```
--------------------------------------------------------------------------------
OHIO,RAYMOND  123-45-6789                                    PROCEDURE REPORT
--------------------------------------------------------------------------------
NOTE DATED: 02/13/2002 00:00  PROCEDURE REPORT

SUBJECT: Case #: 267236

PREOPERATIVE DIAGNOSIS:  RESPIRATORY FAILURE, PROLONGED TRACHEAL INTUBATION
                         AND FAILURE TO WEAN

POSTOPERATIVE DIAGNOSIS:  SAME

PROCEDURE PERFORMED:  OPEN TRACHEOSTOMY

PROVIDER:  DR. SPRINGFIELD

ASSISTANT PROVIDER:

ANESTHESIA:  GENERAL ENDOTRACHEAL ANESTHESIA

ESTIMATED BLOOD LOSS:  MINIMAL

COMPLICATIONS:  NONE

INDICATIONS FOR PROCEDURE:  The patient is a sixty-four-year-old gentleman
with a rather extensive past surgical history, mostly significant for status
post esophagogastrectomy and presented to the hospital approximately three
weeks ago with abdominal pain. Diagnostic evaluation consisted of an abdominal
CT scan, liver function tests and right upper quadrant ultrasound, all of
which were consistent with a diagnosis of acalculus cholecystitis. Because of
these findings, the patient was brought to the operating room approximately
three weeks ago where an open cholecystectomy was performed. The patient subsequent to that has
had a very rocky postoperative course, most significantly focusing around persistently spiking
fevers with sources significant for an E-coli sinusitis as well as a Staphylococcus E-coli
pneumonia with no evidence of bacteremia. As a result of all of this sepsis and persistent
spiking fevers, the patient has had a pneumonia, the patient has had a rather difficult time
weaning from the ventilator and because of the
almost three week period since his last operation with persistent endotracheal
tube in place, the patient was brought to the operating room for an open
tracheostomy procedure.

DESCRIPTION OF PROCEDURE:  After appropriate consent was obtained from the
patient's next of kin and the risks and benefits were explained to her, the
patient was then brought to the operating room where general endotracheal
anesthesia was induced. The area was prepped and draped in the usual fashion
with a towel roll under the patient's scapula and the neck extended.

A longitudinal incision of approximately 2 cm was made just below the cricoid
cartilage. The strap muscles were taken down using Bovee electrocautery. The
isthmus of the thyroid was clamped and tied off using 2-0 silk x two.
Hemostasis was assured. The thyroid cartilage was carefully dissected
directly onto it. The window in the third ring of the trachea was opened
after placement of retraction sutures of 0 silk, The hatch was cut open using
a hatch box shape. This opening was then dilated using the tracheal dilator.
The endotracheal tube was pulled back. A #7 Tracheostomy tube was placed with
ease. Breath sounds were assured. The patient was oxygenating well and the
stay sutures were placed. The patient tolerated the procedure well. The skin
was closed with 0 silk and trachea tip was applied. The patient tolerated the
procedure well. The endotracheal tube was finally removed. He was brought to
the Surgical Intensive Care Unit in stable, but critical condition.

Jack Springfield, M.D.

JS/jer:jw J#:  514 DD:  02-13-02 DT:  02-13-02

                  Signed by: /es/ JACK SPRINGFIELD
                                 02/13/2002 16:40
Enter RETURN to continue or '^' to exit: ^
```

Tissue Examination Report
[SROTRPT]

The *Tissue Examination Report* option is used to generate the Tissue Examination Report that contains information about cultures and specimens sent to the laboratory for a non-OR procedure.

This report prints in an 80-column format and can be viewed on the screen.

Example: Tissue Examination Report

```
Select Non-O.R. Procedures (Enter/Edit) Option: TR  Tissue Examination Report
DEVICE: [Select Print Device]

-----------------------------------printout follows--------------------------------

------------------------------------------------------------------------------
     MEDICAL RECORD   |                    TISSUE EXAMINATION
------------------------------------------------------------------------------
Specimen Submitted By:                            Obtained: AUG 13, 2004
   OR1,  SURGERY CASE # 267260
------------------------------------------------------------------------------
Specimen(s): BIOPSY OF STOMACH LINING
------------------------------------------------------------------------------
Brief Clinical History:
The patient has had a pneumonia, and had a rather difficult time weaning
from the ventilator and because of the almost three week period since
his last operation with persistent endotracheal tube in place, the
patient was brought to the operating room for an open tracheostomy procedure.
------------------------------------------------------------------------------
Operative Procedure(s):
   OPEN TRACHEOSTOMY
------------------------------------------------------------------------------
Preoperative Diagnosis:
   RESPIRATORY FAILURE, PROLONGED TRACHEAL INTUBATION
   AND FAILURE TO WEAN
------------------------------------------------------------------------------
Operative Findings:

------------------------------------------------------------------------------
Postoperative Diagnosis:                          Signature and Title
   FOREIGN BODY IN TRACHEA                              TULSA,LARRY
------------------------------------------------------------------------------
Attending Surgeon: TOPEKA,MARK
------------------------------------------------------------------------------
                             PATHOLOGY REPORT
------------------------------------------------------------------------------
Name of Laboratory                                Accession Number(s)

------------------------------------------------------------------------------
Gross Description, Histologic Examination and Diagnosis



                             (Continue on reverse side)
------------------------------------------------------------------------------
PATHOLOGIST'S SIGNATURE                                    DATE:
------------------------------------------------------------------------------
NEBRASKA,NICK (123-45-6789)  Age: 64   SEX: MALE         ID # 123-45-6789
ETHNICITY: NOT HISPANIC                                   REGISTER NO.
RACE: WHITE, ASIAN
WARD:                        ROOM-BED:
------------------------------------------------------------------------------
VAMC: MAYBERRY, NC                                        REPLACEMENT FORM 515

Press RETURN to continue
```

Non-OR Procedure Information
[SR NON-OR INFO]

The *Non-OR Procedure Information* option displays information on the selected non-OR procedure, with the exception of the provider's dictated summary.

This report prints in an 80-column format and can be viewed on the screen.

Example: Non-OR Procedure Information

```
NEBRASKA,NICK (123-45-6789)   Case #267260 – AUG 13,2002

Select Non-O.R. Procedures (Enter/Edit) Option: I  Non-O.R. Procedure Information

DEVICE: HOME// [Select Print Device]T

-----------------------------------printout follows--------------------------------

NEBRASKA,NICK (123-45-6789)  Age: 64                                    PAGE 1
NON-O.R. PROCEDURE - CASE #267260                  Printed: AUG 13, 2004@14:40
------------------------------------------------------------------------------

Med. Specialty: PULMONARY, NON-TB           Location: NON OR

Principal Diagnosis:
  FAILURE TO WEAN                           ICD9 Code: 934.0

Provider: TULSA,LARRY                           Patient Status: INPATIENT
Attending: MIAMI,STEVE
Attending Code: LEVEL F: NON-OR PROCEDURE DONE IN THE OR, ATTENDING IDENTIFIED

Attend Anesth: N/A
Anesthesia Supervisor Code: N/A
Anesthetist: N/A

Anesthesia Technique(s): N/A

Proc Begin:  AUG 13, 2004  09:00        Proc End:  AUG 13, 2004  10:00

Procedure(s) Performed:
  Principal: OPEN TRACHEOSTOMY
    CPT Code: 31600  INCISION OF WINDPIPE

Indications for Procedure:
  FOREIGN BODY IN TRACHEA.

Brief Clinical History:
  The patient is a sixty-four-year-old gentleman with a rather extensive past
surgical history, mostly significant for status post esophagogastrectomy and
presented to the hospital approximately three weeks ago with abdominal pain.
Diagnostic evaluation consisted of an abdominal CT scan, liver function
tests and right upper quadrant ultrasound, all of which were consistent
with a diagnosis of acalculus cholecystitis. Because of these findings,
the patient was brought to the operating room approximately three weeks ago
where an open cholecystectomy was performed.


Specimens: BIOPSY OF STOMACH LINING.


Dictated Summary Expected: YES

Enter RETURN to continue or '^' to exit:
```

Annual Report of Non-O.R. Procedures
[SRONOP-ANNUAL]

The *Annual Report of Non-O.R.. Procedures* option generates the Annual Report of Non-O.R. Procedures. It displays the total number of non-O.R. procedures within the selected date range based on CPT code.

This report prints in an 80-column format and can be viewed on the screen.

Example: Annual Report of Non-O.R. Procedures

```
Select Non-O.R. Procedures Option:  A  Annual Report of Non-O.R. Procedures

Annual Report of Non-O.R. Procedures


Starting with Date: 3/2  (MAR 02, 1999)
Ending with Date: 3/30  (MAR 30, 1999)

Print the report on which Device: [Select Print Device]
```

----------*report follows*----------

CPT/ICD9 Coding Menu
[SRCODING MENU]

The Surgery *CPT/ICD9 Coding Menu* option was developed to help assure access to the most accurate source documentation and to provide a means for efficient coding entry and validation. It provides coders with special, limited access to the **V***IST***A** Surgery package.

From the menu, coders have ready access to the Operation Report, which is dictated by the surgeon postoperatively and contains the most comprehensive and accurate description of the procedure(s) actually performed. Coders can also view the Nurse Intraoperative Report, which is often an important supplementary source of data.

Using the same menu, coders can add and edit procedures, CPT codes, diagnoses, and International Classification of Diseases 9th Edition (ICD-9) codes, without having to rely on a paper-based system. Options are available to assist surgery staff and others who perform coding validation, as are several commonly used reports.

The *Surgery CPT/ICD9 Coding Menu* contains the following options. To the left is the shortcut synonym the user can enter to select the option:

Shortcut	Option Name
EDIT CPT/ICD9	*Update/Verify Menu ...*
C	*Cumulative Report of CPT Codes*
A	*Report of CPT Coding Accuracy*
M	*List Completed Cases Missing CPT Codes*
L	*List of Operations*
LS	*List of Operations (by Surgical Specialty)*
U	*List of Undictated Operations*
D	*Report of Daily Operating Room Activity*
PS	*PCE Filing Status Report*
R	*Report of Non-O.R. Procedures*

CPT/ICD9 Update/Verify Menu
[SRCODING UPDATE/VERIFY MENU]

The *CPT/ICD9 Update/Verify Menu* is locked with the SR CODER security key.

This option provides coding personnel with access to review and edit procedure and diagnosis information. It also provides access to the Operation Report and Nurse Intraoperative Report for operations and to the Procedure Report (Non-O.R.) for non-O.R. procedures.

The *CPT/ICD9 Update/Verify Menu* contains the following options. To the left is the shortcut synonym the user can enter to select the option.

Shortcut	Option Name
UV	*Update/Verify Procedure/Diagnosis Codes*
OR	*Operation/Procedure Report*
NR	*Nurse Intraoperative Report*
PI	*Non-OR Procedure Information*

To access the *CPT/ICD9 Update/Verify Menu*, the user must first identify the patient and case. When the user selects **EDIT** for the *CPT/ICD9 Update/Verify Menu* from the *CPT/ICD9 Coding Menu*, the user will be prompted to enter a patient name. The software will then list all the cases on record for the patient, including any operations that are completed or are in progress and any non-O.R. procedures.

```
Select CPT/ICD9 Coding Menu Option: EDIT  CPT/ICD9 Update/Verify Menu

Select Patient: IDAHO,PETER             02-12-28     123456789     YES     S
C VETERAN

 IDAHO,PETER     123-45-6789

1. 08-07-99   REPAIR DIAPHRAGMATIC HERNIA (COMPLETED)

2. 02-24-99   CYSTOSCOPY (NON-OR PROCEDURE)

3. 02-18-03   TRACHEOSTOMY (COMPLETED)

4. 09-04-97   CHOLECYSTECTOMY (COMPLETED)

5. 09-28-95   INGUINAL HERNIA (COMPLETED)

6. 08-31-95   HIP REPLACEMENT (COMPLETED)


Select Case: 3

 IDAHO,PETER (123-45-6789)   Case #124 - FEB 18,1999


   UV     Update/Verify Procedure/Diagnosis Codes
   OR     Operation/Procedure Report
   NR     Nurse Intraoperative Report
   PI     Non-OR Procedure Information

Select CPT/ICD9 Update/Verify Menu Option:
```

From this point, the user can select any of the *CPT/ICD9 Update/Verify Menu* options.

```
1. MITRAL VALVE
Cultures:  N/A

Anesthesia Technique(s):
 GENERAL  (PRINCIPAL)


Tubes and Drains:
  #16FOLEY, #18NGTUBE, #36 &2 #32RA CHEST TUBES

Tourniquet: N/A

Thermal Unit: N/A

Prosthesis Installed:
  Item: MITRAL VALVE
    Vendor: BAXTER EDWARDS
    Model: 6900
    Lot/Serial Number: GY0755                       Sterile Resp: MANUFACTURER
    Size: 29MM                                      Quantity: 1

Medications: N/A

Irrigation Solution(s):
  HEPARINIZED SALINE
  NORMAL SALINE
  COLD SALINE

Blood Replacement Fluids: N/A

Sponge Count:       YES
Sharps Count:       YES
Instrument Count:   NOT APPLICABLE
Counter:            PELHAM,STEVE
Counts Verified By: LANSING,MARY

Dressing: DSD, PAPER TAPE, MEPORE
Packing:  NONE

Blood Loss: 800 ml                     Urine Output: 750 ml

Postoperative Mood:           RELAXED
Postoperative Consciousness:  ANESTHETIZED
Postoperative Skin Integrity: SUTURED INCISION
Postoperative Skin Color:     N/A

Laser Unit(s): N/A

Sequential Compression Device: NO

Cell Saver(s): N/A

Devices: N/A

                  Signed by: /es/ MARY A LANSING
                                  03/04/2002 10:41
```

Non-OR Procedure Information
[SR NON-OR INFO]

The *Non-OR Procedure Information* option displays information on the selected non-OR procedure, with the exception of the provider's dictated summary.

This report prints in an 80-column format and can be viewed on the screen.

Example: Non-OR Procedure Information

```
NEBRASKA,NICK (123-45-6789)   Case #267260 - APR 22,2002


   UV     Update/Verify Procedure/Diagnosis Codes
   OR     Operation/Procedure Report
   NR     Nurse Intraoperative Report
   I      Non-OR Procedure Information

Select CPT/ICD9 Update/Verify Menu Option: I  Non-O.R. Procedure Information

DEVICE: HOME// [Select Print Device]T

-----------------------------------printout follows---------------------------------

NEBRASKA,NICK (123-45-6789)  Age: 83                                    PAGE 1
NON-O.R. PROCEDURE - CASE #267260                 Printed: AUG 04, 2004@14:40
-------------------------------------------------------------------------------

Med. Specialty: GENERAL                      Location: NON OR

Principal Diagnosis: LARYNGEAL/TRACHEAL BURN

Provider: MIAMI,STEVE                      Patient Status: NOT ENTERED
Attending:
Attending Code:

Attend Anesth: N/A
Anesthesia Supervisor Code: N/A
Anesthetist: N/A

Anesthesia Technique(s): N/A

Proc Begin:  JAN 14, 2004  08:00        Proc End:  JAN 14, 2004  09:00

Procedure(s) Performed:
  Principal: BRONCHOSCOPY
     CPT Code: 31622       DX BRONCHOSCOPE/WASH


Dictated Summary Expected: YES

Enter RETURN to continue or '^' to exit:
```

(This page included for two-sided copying.)

Cumulative Report of CPT Codes
[SROACCT]

The *Cumulative Report of CPT Codes* option counts and reports the number of times a procedure was performed (based on CPT codes) during a specified date range. There is also a column showing how many times it was in the Other Operative Procedure category.

After the user enters the date range, the software will ask if the user wants the Cumulative Report of CPT Codes to include only operating room surgical procedures, non-O.R. procedures, or both.

These reports have a 132-column format and are designed to be copied to a printer.

Example 1: Print the Cumulative Report of CPT Codes for only OR Surgical Procedures

```
Select CPT/ICD9 Coding Menu Option: C  Cumulative Report of CPT Codes

Cumulative Report of CPT Codes

Start with Date: 3/28  (MAR 28, 1999)
End with Date: 4/3  (APR 03, 1999)

Include which cases on the Cumulative Report of CPT Codes ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures.

Select Number:  1// <Enter>

This report is designed to use a 132 column format.


Select Device: [Select Print Device]
```

----------printout follows----------